



## Is "Gender Identity Disorder" an Appropriate Psychiatric Diagnosis?

**YES:** Mercedes Allen, from "Destigmatization Versus Coverage and Access: The Medical Model of Transsexuality" at <http://deniedbluemercedes.wordpress.com/2008/04/05/destigmatization-versus-coverage-and-access-the-medical-model-of-transsexuality/> (2008)

**NO:** Kelley Winters, from GID Reform Advocates, "Issues of GID Diagnosis for Transsexual Women and Men" from <http://www.gidreform.org/GID30285a.pdf> (2007)

### ISSUE SUMMARY

**YES:** Mercedes Allen, educator, trainer, and founder of *AlbernaTrans.org*, recognizes the bias in the DSM's classification of Gender Identity Disorder as a mental disorder, but argues that changes run the risk of leaving the trans community at risk of losing medical care and treatment.

**NO:** Kelley Winters, Ph.D, writer and founder of GID Reform Advocates, argues the inclusion of Gender Identity Disorder in the DSM adds to the stigma faced by transpersons and that reclassification is necessary in order to adequately address the population's health care needs.

**G**ender identity can be a difficult concept to describe. Many people have probably never given much thought to questions of how they feel about themselves in terms of maleness or femaleness. It is assumed that most people have a gender identity that is congruent with their anatomical sex. While some men may feel more (or less) masculine than others, the majority strongly identify as male. The same could be said for most women—regardless of how feminine they feel (or don't feel), the majority identify as women. If asked, most women would probably say they feel like a woman. Most men simply feel like a man. But what does it mean to "feel" like a woman or a man? What is it to "feel" feminine or masculine? Is there only one type of femininity? One style of masculinity? And what about those who feel that their gender identity, their feeling of maleness or femaleness, doesn't match their birth sex? For those whose

gender does not match societal expectations for a person of their anatomical sex, gender identity can be hard to ignore. Their gender identities do not fit the binary gender system that is firmly in place in American society. Because of this, a diagnosis of Gender Identity Disorder (GID) has been applied to those who identify as transgender or transsexual. This diagnosis can be found in the Diagnostic and Statistical Manual of Mental Disorders, commonly referred to as the DSM, published by the American Psychiatric Association.

In 2012, an updated, fifth edition of the DSM will be published (Melby, 2009). Over the years, new editions have been greatly anticipated to see what changes occur. With each edition, new disorders have been identified, adding to the list of mental illnesses. Diagnostic criteria for others have been refined and some behaviors, once defined as disordered, have been removed because they no longer meet the criteria for diagnosis as a mental illness. An example of this is homosexuality. In the DSM-II, published in 1968, homosexuality was considered a mental illness. The 1973 publication of the DSM-III did not list homosexuality as a disorder. This declassification erased some of the stigma associated with same-sex attraction and provided a boost to the gay rights movement in the United States (Melby, 2009).

As the release of the DSM-V draws closer, experts from various fields, appointed to an array of work groups, are holding meetings to discuss what should be added, revised, or removed. For those interested in the field of human sexuality, much attention is being given to the status of GID. There has even been controversy over those appointed to the Sexual and Gender Identity Disorders Work Group (National Gay and Lesbian Task Force, 2008). The changes made to the upcoming DSM-V concerning GID, or the lack thereof, could have great impact on the lives of transgender individuals.

In an essay entitled *Destigmatization Versus Coverage and Access: The Medical Model of Transsexuality*, Mercedes Allen argues that the removal of Gender Identity Disorder from the DSM would put access to mental health care, hormonal treatments, and surgeries needed by some transsexual individuals at risk of being denied. Kelly Winters, in an essay called *Issues of GID Diagnosis for Transsexual Women and Men*, argues that the inclusion of GID in the DSM only serves to stigmatize the transgender and transsexual community, while failing to promote hormonal or surgical treatments as medical necessities.

### References

- T. Melby, "Creating the DSM-V," *Contemporary Sexuality* (vol. 43, no. 3) (2009). National Gay and Lesbian Task Force, "Task Force Questions Critical Appointments to APA's Committee on Sexual and Gender Identity Disorders," accessed at [http://www.thetaskforce.org/press/releases/PR\\_052808](http://www.thetaskforce.org/press/releases/PR_052808) (2008).

## Destigmatization Versus Coverage and Access: The Medical Model of Transsexuality

In recent years, the GLB community has been more receptive to (and even energized in) assisting the transgender community, but regularly asks what its needs are. One that is often touted is the “complete depathologization of Trans identities” (quoting from a press release for an October 7, 2007, demonstration in Barcelona, Spain) by removing “Gender Identity Disorder” (GID) from medical classification. The reasoning generally flows in a logic chain stating that with homosexuality removed from the Diagnostic and Statistical Manual (DSM, the “bible” of the medical community) in 1974, gay and lesbian rights were able to follow as a consequence—and with similar removal, we should be able to do the same. Living in an area where GRS (genital reassignment surgery) is covered under provincial Health Care, however, provides a unique perspective on this issue. And with Presidential candidates proposing models for national health care in the U.S., it would obviously be easier to establish GRS coverage for transsexuals at the ground floor, rather than fight for it later. So it is important to note, from this “other side of the coin,” how delisting GID could do far more harm than good.

Granted, there are concerns about the current classification as a “mental disorder,” and certainly as a transgender person myself, it’s quite unnerving that my diagnosis of GID puts me in the same range of classification as things such as schizophrenia or even pedophilia. And when the emotional argument of “mental unfitness” can lead to ostracism, discrimination in the workplace or the loss of custody and/or visitation rights of children, there are some very serious things at stake. But when the lobbies are calling for a reclassification—or more dramatically a total declassification—of GID, one would expect that they had a better medical and social model to propose. They don’t.

### Basic Access to Services

The argument for complete declassification is a great concern, because unlike homosexuals, transgender people—especially transsexuals—do have medical needs and issues related to their journey. Genital reassignment surgery (GRS), mastectomies and hysterectomies for transmen, tracheal shave, facial hair

removal and breast augmentation for transwomen . . . there are clear medical applications that some require, even to the point of being at risk of suicide from the distress of not having these things available (which is an important point to keep in mind for those in our own communities who assume that GRS is cosmetic surgery and not worthy of health care funding). And we need to use caution about taking psychiatry out of the equation: GID really does affect us psychologically, and we do benefit from having a central source of guidance through the process that keeps this in mind, however flawed and gated the process otherwise might be.

Declassification of GID would essentially relegate transsexuality to a strictly cosmetic issue. Without being able to demonstrate that GID is a real medical condition via a listing in the Diagnostic and Statistical Manual (DSM), convincing a doctor that it is necessary to treat us, provide referrals or even provide a carry letter that will enable us to use a washroom appropriate to our gender presentation could prove to be very difficult, if not impossible. Access to care is difficult enough *even with* the DSM-IV recommending the transition process—imagine the barriers that would be there without it weighing in on that! And with cases regarding the refusal of medical services already before review or recently faced in California, Ontario and elsewhere, the availability of services could grow overwhelmingly scarce.

### A Model of Medical Coverage

And then there is health care coverage, which often causes a lot of issues of itself, usually of the “not with my tax money” variety. But no one just wakes up out of the blue and decides that alienating themselves from the rest of the world by having a “sex change” is a good idea. Science is developing a greater understanding that physical sex and psychological gender can, in fact, be made misaligned, causing a person to be like a stranger in their own body. In extreme cases (transsexuals), this often makes it impossible to function emotionally, socially, sexually, or to develop any kind of career—and often makes one constantly borderline suicidal. The medical community currently recognizes this with the existing medical classification, which is why GRS surgery is the recognized treatment, and why it (GRS, that is, and usually not things like breast augmentation) is funded by some existing health plans.

Canada provides an interesting model on this, as the nation has universal health care, and several provinces fund GRS with some limitations (British Columbia, Newfoundland, Saskatchewan and Quebec fund vaginoplasty, hysterectomy and breast reduction for FTMs, Alberta funds those plus phalloplasty, and Manitoba funds 60% of GRS-related costs). Funding may be restored in Ontario and gained in Nova Scotia, pending some ongoing activism.

This exists specifically because it is classified as a medical issue, and is treated according to the recommendations of WPATH. There are some idiosyncracies, of course—a diagnosis of Intersex, for example, overrides a diagnosis of GID, and if someone is diagnosed as IS, the treatment is different (namely, GRS is not covered). Phalloplasty and metoidioplasty (FTM surgeries) are not covered in several areas because they are considered “experimental.” Some

provinces insist on treatment only in publically-funded hospitals, resulting in the rather unusual situation of Quebec sending patients to the U.S. or overseas, even though one of the top-rated (but privately-owned) GRS clinics in the world is located in Montreal. And many provinces direct transsexuals to the notoriously restrictive and obstacle-laden Clarke Institute (CAMH in Toronto) for treatment. Waiting lists can be long, and only a select few GID-certified psychiatrists are able to be a primary signature on letters authorizing surgery and funding. Still, the funding provides opportunity that many non-Canadian transsexuals would leap at within a moment, if they could.

## Future Considerations

This possibility, remote as it may seem, is also out there for future American transsexuals. Both Democratic Presidential nominees have discussed developing a national health care program. The time is now for the trans, gay/lesbian/bisexual and allied communities to lobby insurance companies to develop policies that cover GRS. The time is now to lobby companies to seek out group policies for their employees with such coverage, and with more emphasis than the HRC's impossibly easy Corporate Equality Index (CEI), in which providing mastectomies for breast cancer patients qualifies as "transgender-related surgeries." The more prevalent health care coverage is for transgender persons when a national program is developed, the more effective the argument is that a national program should include it. Certainly, it will be much harder to lobby to have it specifically added later.

This possibility, remote as it may seem, exists because of the current classification. Even some existing coverage of and access to hormone treatment is called into question in a declassification scenario. And certainly, where coverage is not available, it is the impoverished, disenfranchised and marginalized of our community—who quite often have more to worry about than the stigma of mental illness—who lose the most.

So a total declassification is actually not what's best for the transgender community. Too, if anyone had been thinking that proclaiming that "transsexuals is not a mental disorder" would magically change the way that society thinks about transfolk, then they are spectacularly and embarrassingly wrong.

## The Question of Reclassification

At some point in the future, I expect that we will find more biological bases for GID, and that transgender people will perhaps become a smaller part of the larger intersex community (rather than the other way around). Recent studies in genetics have demonstrated some difference in chromosomal structure in male brains versus female brains, and the UCLA scientists who conducted the study have also proposed that their findings demonstrate gender dysphoria as a biological characteristic. Other studies into endocrine disrupting chemicals (EDCs) could open new discoveries related to variance in gender correlation. A reassessment of GID is almost certainly something that will be on the medical

community's table at some point in the future, but it definitely needs to be in the DSM somewhere. But for now, GID is not something that can be determined by a blood test or an ultrasound, and is not easy to verifiably place with biological conditions. The science is not there; the evidence and solutions are not yet at hand.

This is why reclassification is not yet feasible. It's difficult to convince scientific and medical professionals to move a diagnosis when the current model is workable in their eyes (even if not perfect), while the alternatives are not yet proven, cannot be demonstrated as more valid than the current listing, and no modified treatment system has been devised or proposed. Any move of the diagnosis is not likely to be very far from the current listing, and from the literature I've seen, I doubt that those in the community who advocate to change or dropping the current classification would be happy with that. For some, even listing it as a "physical disability" could constitute an "unwanted stigma." I have heard one WPATH doctor suggest the term "Body Morphology Disorder"—for many, I suspect, this would still be too "negative."

## "Unnecessary Mutilation"

That's not to say that complacency is an answer. In the face of conservative reluctance and new activism on the left by the likes of Julie Bindel, claiming that GRS is "unnecessary mutilation," we need to demonstrate the necessity of treatments, in order to ensure that any change would be an improvement on the existing model, rather than a scrapping of it. This is, of course, something that affects a small portion of the transgender community in the full umbrella stretch of the term, but the need for those at the extreme on the spectrum is profound—not simply a question of quality of life, but often one of living at all—or at least a question of being able to function. If and when a reclassification occurs, it will need to be this sense of necessity that will determine the shape of what will be written into any revision.

The solution isn't to destroy the existing medical model by changing or eliminating the current classification of "Gender Dysphoria." Collecting data, demonstrating needs, fighting for inclusion in existing health plans, examining verifiable and repeatable statistics on transgender suicide and success rates and other information relevant to the medical front is where medical-related activism should be focused, for the moment.



## GID Reform Advocates

### Issues of GID Diagnosis for Transsexual Women and Men

Gender Identity Disorder in Adolescents or Adults, 302.85

#### Section: Sexual and Gender Identity Disorders Subsection: Gender Identity Disorders

"Gender Identity Disorder" (GID) is a diagnostic category in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association (APA, 1994). The DSM is regarded as the medical and social definition of mental disorder throughout North America and strongly influences the *The International Statistical Classification of Diseases and Related Health Problems* (ICD) published by the World Health Organization. GID currently includes a broad array of gender variant adults and children who may or may not be transsexual and may or may not be distressed or impaired. GID literally implies a "disordered" gender identity.

Thirty-four years after the American Psychiatric Association (APA) voted to delete homosexuality as a mental disorder, the diagnostic categories of "gender identity disorder" and "transvestic fetishism" in the *Diagnostic and Statistical Manual of Mental Disorders* continue to raise questions of consistency, validity, and fairness. Recent revisions of the DSM have made these diagnostic categories increasingly ambiguous, conflicted and overinclusive. They reinforce false, negative stereotypes of gender variant people and at the same time fail to legitimize the medical necessity of sex reassignment surgeries (SRS) and procedures for transsexual women and men who urgently need them. The result is that a widening segment of gender non-conforming youth and adults are potentially subject to diagnosis of psychosexual disorder, stigma and loss of civil liberty.

### A Question of Legitimacy

The very name, Gender Identity Disorder, suggests that cross-gender identity is itself disordered or deficient. It implies that gender identities held by diagnosable people are not legitimate, in the sense that more ordinary gender identities are, but represent perversion, delusion or immature development. This message

From <http://www.gidreform.org/GID30285a.pdf>, 2007, pp. 1-5 (refs. omitted). Copyright © 2007 by Kelley Winters. Reprinted by permission.

is reinforced in the diagnostic criteria and supporting text that emphasize difference from cultural norms over distress for those born in incongruent bodies or forced to live in wrong gender roles.  
Under the premise of "disordered" gender identity, self-identified transwomen and trans-men lose any rightful claim to acceptance as women and men, but are reduced to mentally ill men and women respectively.

#### DIAGNOSTIC CRITERIA (APA 2000, P 581)

- A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.
- B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.
- C. The disturbance is not concurrent with a physical intersex condition.
- D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify if (for sexually mature individuals) Sexually Attracted to Males, . . . Females, . . . Both, . . . Neither.

### Maligning Terminology

Of the disrespectful language faced by gender variant people in North America, none is more damaging or hurtful than that which disregards their experienced gender identities, denies the affirmed gender roles of those who have transitioned full time and relegates them to their assigned birth sex. Throughout the diagnostic criteria and supporting text, the affirmed gender identities and social role for transsexual individuals is termed "other sex." In the supporting text, subjects are offensively labeled by birth sex and not their experienced affirmed gender. Transsexual women are repeatedly termed "males," and "he." For example,

For some males . . . , the individual's sexual activity with a woman is accompanied by the fantasy of being lesbian lovers or that his partner is a man and he is a woman. (APA, 2000, p. 577, emphasis noted by underline)

Perhaps most disturbing, the term "autogynephilia" was introduced in the supporting text of the DSM-IV-TR to demean lesbian transsexual women:

Adult males who are sexually attracted to females, . . . usually report a history of erotic arousal associated with the thought or image of one self as a woman (termed *autogynephilia*). (p. 578, emphasis noted by underline)

The implication is that all lesbian transsexual women are incapable of genuine affection for other female partners but are instead obsessed with narcissistic paraphilia. The fact that most ordinary natal women possess images of themselves as women within their erotic relationships and fantasies is conspicuously overlooked in the supporting text.

## Medically Necessary Treatment of Gender Dysphoria

Gender Dysphoria is defined in the DSM-IV-TR as:

A persistent aversion toward some or all of those physical characteristics or social roles that connote one's own biological sex (APA, 2000, p. 823).

The focus of medical treatment described by the current World Professional Association for Transgender Health Standards of Care is on relieving the distress of gender dysphoria and not on attempting to change one's gender identity (WPATH, 2001). Yet, the DSM-IV-TR emphasizes cross-gender identity and expression rather than the distress of gender dysphoria as the basis for mental disorder. While criterion B of Gender Identity Disorder may imply gender dysphoria, it is not limited to ego-dystonic subjects suffering distress with their born sex or its associated role. Ego-syntonic subjects who do not need medical treatment may also be ambiguously implicated. In failing to distinguish gender diversity from gender distress, the APA has undermined the medical necessity of sex reassignment procedures for transsexuals who need them. It is little wonder that the province of Ontario and virtually all insurers and HMOs in the U.S. and have denied or dropped coverage for sex reassignment surgery (SRS) procedures. Since gender dysphoria is not explicitly classified as a treatable medical condition, surgeries that relieve its distress are easily dismissed as "cosmetic" by insurers, governments and employers.

The transgender community and civil rights advocates have long been polarized by fear that access to SRS procedures would be lost if the GID classification were revised. In truth, however, transsexuals are poorly served by a diagnosis that stigmatizes them unconditionally as mentally deficient and at the same time fails to establish the medical necessity of procedures proven to relieve their distress.

## Overinclusive Diagnosis

Distress and impairment became central to the definition of mental disorder in the DSM-IV (1994, p. xxi), where a generic clinical significance criterion was added to most diagnostic categories, including criterion D of Gender Identity Disorder. Ironically, while the scope of mental disorder was narrowed in the DSM-IV, Gender Identity Disorder was broadened from the classification of Transsexualism in prior DSM revisions and combined with Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT) from the DSM-III-R (1987, pp. 74-77).

Unfortunately, no specific definition of distress and impairment is given in the GID diagnosis. The supporting text in the DSM-IV-TR lists relationship difficulties and impaired function at work or school as examples of distress and disability (2000, p. 577) with no reference to the role of societal prejudice as the cause. Prostitution, HIV risk, suicide attempts and substance abuse are described as associated features of GID, when they are in truth consequences of discrimination and undeserved shame. The DSM does not acknowledge the existence of many healthy, well-adjusted transsexual or gender variant people or differentiate them from those who could benefit from medical treatment. These are left to the interpretation of the reader. Tolerant clinicians may infer that transgender identity or expression is not inherently impairing, but that societal intolerance and prejudice are to blame for the distress and internalized shame that transpeople often suffer (Brown, 1995). Intolerant clinicians are free to infer the opposite: that cross-gender identity or expression by definition constitutes impairment, regardless of the individual's happiness or well-being. Therefore, the GID diagnosis is not limited to ego-dystonic subjects; it makes no distinction between the distress of gender dysphoria and that caused by prejudice and discrimination. Moreover, the current DSM has no clear exit clause for transitioned or post-operative transsexuals, however well adjusted. It lists postsurgical complications as "associated physical examination findings" of GID (2000, p. 579).

## Pathologization of Ordinary Behaviors

Conflicting and ambiguous language in the DSM serves to confuse cultural nonconformity with mental illness and pathologize ordinary behaviors as symptomatic. The Introduction to the DSM-IV-TR (2000, p. xxxi) states:

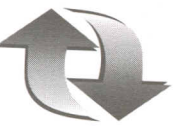
Neither deviant behavior ... nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of dysfunction...

However, it is contradicted in the Gender Identity Disorder section (p. 580):

Gender Identity Disorder can be distinguished from simple nonconformity to stereotypical sex role behavior by the extent and pervasiveness of the cross-gender wishes, interests, and activities.

The second statement implies that one may deviate from social expectations without a diagnostic label, but not too much. Conflicting language in the DSM serves the agendas of intolerant relatives and employers and their medical expert witnesses who seek to deny transgender individuals their civil liberties, children and jobs.

In the supporting text of the Gender Identity Disorder diagnosis, behaviors that would be ordinary or even exemplary for ordinary women and men are presented as symptomatic of mental disorder on a presumption of incongruence with born genitalia. These include passing, living and a desire to be treated as ordinary members of the preferred gender. For example, shaving legs for adolescent biological males is described as symptomatic, even though it is common among males involved in certain athletics. Adopting ordinary behaviors, dress and mannerisms of the preferred gender is described as a manifestation of preoccupation for adults. It is not clear how these behaviors can be pathological for one group of people and not for another.



## POSTSCRIPT



### Is “Gender Identity Disorder” an Appropriate Psychiatric Diagnosis?

It is important to realize that, while both Allen and Winters take opposing sides to the question presented, both oppose the labeling of transgender or transsexual individuals as mentally ill. To a certain extent, the debate over the inclusion, reclassification, or exclusion of GID in the upcoming edition of the DSM exemplifies the phrase “You’re damned if you do, you’re damned if you don’t.” To remove GID from the DSM would in all likelihood help to reduce some of the stigma attached to transsexuality. However, many transsexual individuals need a diagnosable condition in order to receive adequate coverage for medical care. Could there possibly be a “correct” answer in this situation?

Allen’s essay, which acknowledges the stigma attached to the label of mental disorder and notes the possible benefits of re- or declassification of GID, focuses on the issue of access to medical care. The point is made that declassification would impact transgender and transsexual individuals in much different ways than the declassification of homosexuality affected gay men and lesbians. Unlike other sexual minorities, “transgender people—especially transsexuals—do have medical needs and issues related to their journey,” Allen states. What would be the risks of removing GID from the upcoming DSM? Why would some transgender advocates argue for its continued inclusion? Allen also mentions the impact of nationalized health care on the GID debate. How would the discussion be different if the United States implemented health care coverage for all citizens?

Winters focuses on deconstructing the current diagnosis of GID. Despite recent revisions, she states, the diagnostic criteria are “increasingly ambiguous, conflicted and overinclusive.” After reading the most recent DSM criteria for GID, included in her essay, would you agree? Fears that a revised classification would endanger medical care for the transgender community are essentially moot, states Winters, given the fact that the current diagnosis “fails to establish the medical necessity of procedures proven to relieve their distress.” With the criteria put in place by the DSM, Winters argues, many insurers are already refusing to cover treatments, dismissing surgeries as “cosmetic” in nature, rather than necessary for treatment.

Do you feel that total declassification is the correct step to take? Or would a revision of the current classification be more appropriate? What if these changes resulted in the denial of access to medical care for transgender or transsexual individuals? Is there a middle ground that reduces stigma while maintaining access to medical treatment?

## Suggested Readings

- P.T. Cohen-Kettenis, "The Treatment of Adolescent Transsexuals," *Journal of Sexual Medicine* (vol. 5, no. 8, 2008).
- R. Ehrbar, "Clinical Judgment in the Diagnosis of Gender Identity Disorder in Children," *Journal of Sex and Marital Therapy* (vol. 34, no. 5, 2008).
- K. Hausman, "Controversy Continues to Grow over DSM's GID Diagnosis," *Psychiatric News* (vol. 38, no. 14, 2003). Accessed at <http://pn.psychiatryonline.org/cgi/content/full/38/14/25>.



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